

Case Number:	CM13-0033068		
Date Assigned:	12/06/2013	Date of Injury:	06/06/2009
Decision Date:	05/14/2014	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/17/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Geriatrics and is licensed to practice in New York. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 40-year-old woman with a date of injury of August 6, 2012. She was seen by her provider on September 13, 2013 with complaints of 5-8/10 pain, which is in her posterior neck, low back, upper back and mid back. She is status post low back surgery on August 6, 2012 and numerous diagnostic studies and therapeutic modalities. Her physical exam showed discomfort and pain in the cervical region bilaterally (grade 3) and tenderness in the lumbar region bilaterally (grade 3). A dynamometer showed right: 60, 50, 50 and left: 60, 50, and 50. Her diagnoses included post-op thoracic spine - failed, cervicobrachial syndrome, thoracalgia, lumbar facet syndrome, sacroiliitis, post-surgical tachycardia, fibromyalgia and probable gastritis from medications. The plan was to continue medications including narcotics, muscle relaxants, anti-depressants and topical agents, an MRI to the cervical and thoracic spine and EMG/NCV to bilateral upper and lower extremities. The upper extremity studies are at issue in this review

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Electromyogram (EMG) of the Left Upper Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation ODG Neck and Upper Back, Electromyography (EMG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-193.

Decision rationale: According to the ACOEM Guidelines electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging for neural or other soft tissue, compute tomography scan for bony structures). The history and physical exam documented by the provider do not support radicular symptoms or weakness or the medical necessity for an EMG of the left upper extremity.

Electromyogram (EMG) of the Right Upper Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation ODG Neck and Upper Back, Electromyography (EMG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-193.

Decision rationale: According to the ACOEM Guidelines electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging for neural or other soft tissue, compute tomography scan for bony structures). The history and physical exam documented by the provider do not support radicular symptoms or weakness or the medical necessity for an EMG of the right upper extremity

Nerve Conduction Velocity (NCV) of the Left Upper Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation ODG Neck and Upper Back, Nerve Conduction Studies (NCS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-193.

Decision rationale: According to the ACOEM Guidelines electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four

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Nerve Conduction Velocity (NCV) of the Right Upper Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation ODG Neck and Upper Back, Nerve Conduction Studies (NCS).

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Decision rationale: Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging for neural or other soft tissue, compute tomography scan for bony structures). The history and physical exam documented by the provider do not support radicular symptoms or weakness or the medical necessity for a NCV of the left upper extremity